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LOYOLA UNIVERSITY CHICAGO

AN EVALUATION OF A HOSPITAL-BASED PROGRAM DESIGNED  
TO TREAT CHILD SEXUAL ABUSE VICTIMS

A THESIS SUBMITTED TO  
THE FACULTY OF THE GRADUATE SCHOOL  
IN CANDIDACY FOR THE DEGREE OF  
MASTER OF ARTS

DEPARTMENT OF PSYCHOLOGY

BY

MICHELE HANSEN

CHICAGO, ILLINOIS

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## CHAPTER I

### INTRODUCTION AND LITERATURE REVIEW

The effectiveness of treatment for child sexual abuse victims has gained increasing attention in recent years due to the amplified awareness regarding the deleterious impact on the child victims and their families. The treatment program presently evaluated was an eclectic approach designed to ameliorate children's subjective distress, decrease the negative behavioral ramifications of child sexual abuse, enhance children's perceived self-efficacy beliefs, increase knowledge and prevention skills, and enhance family functioning in the aftermath of the sexual abuse. This evaluation was conducted to add to the knowledge base on child sexual abuse treatment and to serve as a catalyst for the development of effective treatment programs for child sexual abuse victims and their families.

#### Ramifications of Child Sexual Abuse

In recent years the psychological ramifications of sexual abuse on children has received a great deal of attention. Studies have indicated that sexually abused children may manifest a variety of emotional difficulties due to the traumatic experience including increased anxiety and fear (Browne & Finkelhor, 1986), depression (Shapiro, Leifer, Martone, & Kassem, 1992), decreased self-esteem, unmet dependency needs (De Luca, Hazen, & Cutler, 1993), and feelings of loneliness, and helplessness (Nelki & Watters, 1989), and post-traumatic stress (Kiser, Heston, Millsap, & Pruitt, 1991; McLeer, Callaghan,

Henry, & Wallen, 1994). According to Kiser et al. clinical investigations of post-traumatic stress disorder (PTSD) symptoms among sexually abused children revealed the following symptoms: development of trauma-related and/or mundane fears, increased anxiety, sleep disturbances including difficulties in going to bed and falling asleep, nightmares, regressive bed-wetting, eating disturbances, excessive guilt feelings, acting out or withdrawal behavior, persistent re-experiencing or recapitulating the event, persistent avoidance of stimuli associated with the trauma, general numbing of responsiveness, and increased arousal and nervousness.

Finkelhor and Browne (1986) state that the impact of child sexual abuse can be understood in terms of four trauma causing factors or what they refer to as “traumagenic dynamics-traumatic sexualization, stigmatization, betrayal, and powerlessness” (p. 180). The *traumatic sexualization* results as misconceptions and confusions about sexual behavior and sexual morality are transmitted to the child from the perpetrator. Feelings of *betrayal* occur because the children often come to realize that a trusted person has manipulated them through lies and/or misrepresentations. The dynamic of *stigmatization* refers to the negative connotations (e.g., shame, guilt, and “damaged goods”) that are conveyed to the victim about the experience and that are subsequently incorporated into the child’s self-concept. Finally, according to these authors, victims often experience *powerlessness* or “disempowerment” as the child victim’s will, desires, and sense of self-efficacy are undermined by the abuse incident and the coercion involved. Additionally, they theorize that a basic kind of powerless results due to the fact in sexual abuse the child’s territory and “body” space are repeatedly imposed upon without the child’s consent.



Investigations have also suggested that sexually abused children exhibit a number of behavior problems including increased sexualized behavior (Friedrich, Grambsch, Damon, Hewitt, Koverola, Wolfe, Lang, & Broughton, 1992), inappropriate aggression and "sexual acting out," (Friedrich, Luecke, Beilke, & Place, 1992) and maladjusted social competence (De Luca et al., 1993). According to Finkelhor and Browne, a child's "sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of the sexual abuse" (p. 180). These authors also state that sexual abuse often occurs through the exchange of affection, attention, and material gifts for sexual behavior and thus, victims subsequently learn that sexual behavior is an effective means for manipulating others to get his/her other developmentally appropriate needs met. Child victims of sexual abuse often emerge from their traumatic experiences with inappropriate repertoires of sexual behavior, with distorted perceptions of their sexual self-concepts, and with atypical emotional reactions to sexual activities. With this in mind, child sexual abuse victims often exhibit a variety of inappropriate behaviors in an effort to cope with the trauma of the abuse experience.

In a series of recent investigations Mannarino and colleagues (Mannarino, Cohen, & Berman, 1992; Mannarino, Cohen, & Gregor, 1989; Mannarino, Cohen, Smith, & Moore-Motily, 1991; Cohen & Mannarino, 1988) employed standardized instruments to examine the psychological impact of sexual abuse on girls by comparing sexually abused girls to non-abused and clinical control subjects. The studies consistently indicated marked discrepancies between child and parent reports of symptoms. For instance, Mannarino et al. (1989) found that sexually abused girls did not exhibit significant depressive, anxiety, or low self-esteem

by self-report; however, their parents rated them as having significantly more behavioral problems than a normative sample but as somewhat less pathological than a clinical sample. However, the sexually abused children were significantly more anxious than both control groups as reported on the A-Trait scale from the State-Trait Anxiety Inventory for Children (Mannarino et al. 1989). These series of investigations revealed the importance of considering parent and/or caretaker perceptions of the sexual abuse victim's distress following the incident.

Childhood sexual abuse has also been found to have a variety of long-term effects including cognitive distortions, altered emotionality, disturbed relatedness, avoidance, impaired self-reference, and adult post-traumatic stress symptoms (Briere & Runtz, 1993). In a study examining the effects of childhood sexual abuse five years after presentation, Swanston, Tebbutt, O'Toole, and Oates (1997) found that in comparison to a matched sample of non-abused children, the sexual abuse victims had significantly higher levels of disturbed behavior, depression, eating disorders, self-injury, and suicide attempts. Researchers have also found that family variables such as level of conflict, cohesion, support, and attachment contribute to the severity of long-term problems experienced by childhood victims (e.g., Alexander, 1993; Friedrich, Beilke, & Urquiza, 1987). Thus, it is important to consider the family context when forming conceptualizations regarding the impact of sexual abuse (Alexander, 1993).

#### Importance of Education About Sexual Abuse and Prevention of Further Victimization

Prevention programs are often appealing because some problems are particularly difficult to treat once they are established (Institute of Medicine, 1994). This is especially

true for child victims of sexual abuse. As described above, the families often undergo a great deal of stress in the aftermath of the incident and the children suffer from a number of traumatic psychological as well as behavioral ramifications. Hazzard (1993) also reports that both males and females are at risk and those who are sexually abused are at increased risk for revictimization. Another important finding is that children that are sexually abused are at an increased risk for becoming offenders in the future (Ryan, 1989). Ryan suggests that this “reenactment” of the situation is an attempt to regain control and to overcome feelings of powerlessness. The program evaluated in this study was designed to incorporate prevention and education components into the therapeutic interventions in an effort to increase protective factors associated with a decreased probability of repeat occurrences of child sexual abuse. In other words, the program was developed to decrease the probability of further victimization for children identified as victims and also decrease the likelihood that these victims will become victimizers in the future.

Although sexually abused children may suffer from a number of physical and emotional symptoms they are unlikely to report the incidents for a variety of reasons. To begin with, reports indicate that children are most likely to be abused by relatives that they are emotionally close to (Elrod & Rubin, 1993). Moreover, perpetrators often convince the child not to report the abuse by explaining it is “their special secret” or they may threaten the child (Hazzard, 1993). In addition, sexually abused children are confused in the aftermath of the abuse and may not recognize that the incident is in fact abusive (Krivacska, 1992).

Due to mounting evidence concerning the disturbing ramifications of child sexual abuse and increased awareness about the high prevalence of incidents, there has been a

proliferation of prevention programs. Numerous formats have been used for presentation of material including films/video tape, lecture/discussion, (e.g., Hazzard, 1993; Hazzard, Webb, Kleemier, Angert, & Pohl 1990) written materials, theatrical presentations, and behavioral skills training procedures (see Carroll, Miltenberger, & O'Neill, 1992 for a review). Current sexual abuse prevention programs (e.g., "Feeling Yes, Feeling No" curriculum implemented by Hazzard and colleagues from 1986 through 1988; Prevention Education curricula implemented by Neiki and Watters, 1989) teach the following major concepts: (a) Touches can give children positive or negative feelings, (b) Children can say no, leave, and tell a trusted adult if someone's touch makes them feel uncomfortable, (c) Sexual assault is when a grown-up or older child touches the private parts of your body (i.e., breasts, vagina, penis, bottom) or asks you to touch or to look at their private parts, (d) Children can problem solve to avoid dangerous situations with strangers, (e) Children are sometimes sexually assaulted by someone they know, (f) There are many adults who can help sexually assaulted children- so keep telling if the first adult does not believe you, and (g) Sexual assault is never the child's fault (Hazzard, 1989, p. 15).

Although a variety of programs have been implemented, evaluations have shown that behavioral skills training are the most effective method of teaching self-protective skills and maintaining skills over time. In addition, an active learning component involving such activities as role playing has been found to be more effective than the passive-learning lecture format. However, these programs have not escaped criticism. Kirvacska (1992) has criticized programs for being developmentally inappropriate as preschoolers do not understand concepts such as "good" touch and "bad" touch, and body ownership.

Additionally, many programs may impair normal sexual functioning in children because they are learning about negative sexual experiences without supplemental discussions of appropriate and healthy sexual activities. Moreover, he contends that such programs that intend to “empower” children may be disempowering them in actuality. He reasons that children may be confused as a perpetrator imposes his/her power/will/control on the child when he/she tells the child not to report the incident while another adult (e.g., teacher) imposes his/her power/will/control on the child by telling the child to report the abuse. Investigations have also indicated limited parental involvement in prevention programs (e.g., Elrod & Rubin, 1992). In addition, parents who report that they would like to teach child sexual abuse prevention to their own children often lack knowledge and the necessary skills to be effective “teachers” (Wurtele, Kvaternick, & Franklin, 1992). For example, Wurtele et al.(1992) report that parents are likely to teach children about stranger abduction but are not likely to educate children about the possibility of being abused by someone close to them.

Taken together reports indicate that children can indeed learn prevention skills and that presenting developmentally appropriate information in context of “normal” sex education may be the most effective way to teach these skills. Prevention programs with active involvement on the part of the children and parents and behavioral skills training may be more successful. Furthermore, programs should provide secondary prevention components so that children who have disclosed victimization can be referred to treatment sources. This may be an effective way not only to alleviate existing trauma, but also to reduce the chances of dysfunction in later adulthood. Moreover, this may serve to decrease the likelihood of further victimization and future perpetration. Due to the fact that the

children in this study were already sexually abused, the present program evaluation focuses exclusively on secondary prevention efforts used to decrease the probability of further victimization and perpetrator behaviors.

### Treatment Approaches Employed For Child Sexual Abuse Victims

A variety of interventions have been recommended for the clinical treatment of child sexual abuse victims including play therapy (Gil, 1991; Gil & Johnson, 1993), family therapy (Glaser, 1991, Cohen & Mannarino, 1993), group therapy (Neiki & Watters, 1989) and cognitive-behavioral interventions (Shapiro et al., 1992). Play therapy is useful as it provides a setting that enables the child to re-enact the abusive experience in thematic play with the therapist's guidance and therapeutic intervention (Gil, 1991). According to Gil's review of play therapy techniques, play therapy is a way for the abused child to develop problem-solving and competence skills by allowing the child to effectively deal with experiences and situations in a structured environment with the therapist. Gil cites Nickerson (1973) who points out that play is an effective therapy technique because it is a natural activity that allows the child to express himself/herself, stimulates the child's communication, "allows for a cathartic release of feelings, can be renewing and constructive, and allows the adult a window to observe the child's world" (p.27). In addition, the child feels comfortable in a play setting and feels natural in playing out concerns and emotional disturbances with toys.

Cognitive behavioral interventions have been used to increase appropriate pro-social behavior, to assist in modifying distressing emotional reactions, and to treat post-traumatic symptoms ( e.g., fears, anxiety, and compulsive repetitions) (Deblinger, McLeer, & Henry,

1990). They have also been used to provide safety education and assertiveness training, identify appropriate and inappropriate touching, examine attributions regarding the abuse and negative and ambivalent feelings toward the perpetrator, and address regressive and inappropriate behaviors (Cohen & Mannarino, 1996). According to Cohen and Mannarino, specific interventions include the use of “cognitive reframing, thought stopping, positive imagery, contingency reinforcement programs, parent management training, and problem solving” (p. 45). Cognitive behavioral interventions often involve training parents in how to foster appropriate behavior and improve the child's adaptive functioning.

Family treatment is often needed as the abuse experience and the subsequent structural changes disrupt and alter family relationships and family functioning (Cohen and Mannarino, 1993). The importance of parent treatments has been emphasized by Lyons (1989), who points out in his work on child trauma survivors that one of the strongest predictors of child treatment outcome is the ability of significant adults to deal with the traumatic events. In a treatment model proposed by Cohen and Mannarino (1996), the following parent issues must be addressed to help the child cope with the emotional reactions to the abuse: parent or primary care-taker's attributions regarding the abuse, perceptions of the child as “damaged” due to the incident, ability to provide appropriate emotional support to the child, management of inappropriate child behaviors (e.g., sexual “acting out”, sexualized behaviors, regressive behaviors) and management of the child's fear and anxiety symptoms. Additionally, in treatment of sexual abuse victims, it may be necessary to address parental issues related to their own abuse history (if applicable) and legal issues. According to Long (1986), due to the child's guilt, fear, and inability to trust, primary care

givers must be made aware that the child may experience inappropriate attachment behavior and an impaired ability to trust.

Last, group treatments have been successful with sexually abused children as groups often provide educational components, the opportunity to process distressing interpersonal feelings, and discussion of interpersonal dynamics that become apparent in the group setting. According to Scott (1992), participation in group therapy can be effective in reducing the child's sense of isolation and shame by providing a safe place for the child to engage in and experiment with behaviors, and amplifying their awareness of issues connected with their abuse. Additionally, the group can provide the child with a group other than their family in which to have their emotional needs expressed and met by others. Group therapy can also serve to challenge the reclusiveness of incestuous families and encourage children to interact as peers with other children.

### Treatment Evaluation Research

Although there is an abundance of literature regarding the characteristics of sexually abused children and therapeutic interventions, there are relatively fewer treatment outcome studies. Moreover, several of the studies reviewed had a number of methodological problems and deficiencies, including use of small sample sizes (e.g., De Luca et al., 1993; Nelki & Watters, 1989), lack of standardized instrumentation (e.g., Nelki & Watters), insufficient descriptions of therapy, subjects and research design, and lack of operational definitions of sexual abuse (e.g., Friedrich et al., 1992). In an extensive review of the literature regarding treatment outcome studies, O'Donohue and Elliot (1992) reported that many treatment outcome studies lack: (a) designs enabling causal inferences regarding treatment, (b)



psychometrically adequate outcome measures, (c) assessment of clinical significance and social validity in addition to statistical significance, (d) inclusion of information that treatment protocols were faithfully implemented, and (e) description of the subject sampling technique and sample size, which limits generalizability. Moreover, most of the treatment outcome studies reviewed relied almost exclusively on anecdotal data, and single case studies. However, in recent years more methodologically sound evaluations have been conducted lending insight into the effectiveness of therapy interventions designed to ameliorate the symptoms of child sexual abuse. Some of these studies are described below.

The effectiveness of cognitive-behavioral treatment for sexually abused children and their parents was examined in an outcome study conducted by Cohen and Mannarino (1996). Sixty-seven sexually abused preschool children and their non-offending parents were either assigned to cognitive-behavioral therapy or non-directive supportive therapy (NST). The non-directive supportive therapy was provided due to the ethical considerations involved in denying or withholding treatment for the sexually abused children and their families in an effort to create a matched control group. The NST was not designed to specifically address sexual abuse issues, but was developed to provide support, build rapport, and encourage the expression of feelings. Results demonstrated that while the NST group did not change significantly with regard to symptomology, the cognitive-behavioral group had highly significant improvements with regard to sexually inappropriate behaviors, behavioral problems, and emotional reactions as indicated by parent self-report.

A similar methodological design was employed to evaluate a specific intervention for treating traumagenic beliefs among sexually abused girls and their mothers (Celano,

Hazzard, Webb, & McCall, 1996). In this study, 32 girls aged 8 to 13 and their nonoffending female caretakers were randomly assigned to either a theoretically based structured program specifically developed to ameliorate post-trauma symptoms or to a more unstructured comparison intervention. The experimental treatment program was based on Finkelhor and Browne's (1985) theoretical model of four traumagenic dynamics intrinsic to child abuse: self-blame/stigmatization, betrayal, traumatic sexualization, and powerlessness. According to the authors, the treatment program used "developmentally appropriate cognitive-behavioral and metaphoric techniques to address children's maladaptive beliefs, affect, and behavior along these four dimensions" (Celano et al., 1996). Both treatment programs resulted in decreases in child post-traumatic stress disorder symptoms and traumagenic beliefs reflecting self-blame, and powerlessness, and increases in children's overall psychosocial functioning. However, the theoretically based experimental intervention was more effective than the comparison group in increasing abuse-related caretaker support of the child and expectations of undue negative impact of the abuse on the child (i.e., parental perceptions that the abuse will have an enduring, irreversible negative impact on the child). The results of this study underscored the importance of developing interventions that address sexually abused children's post-traumatic stress reactions and that help to develop and/or maintain care-taker support of their victimized children. Noteworthy is the fact that this study employed a sample that consisted of primarily low-income African-American families. Other research in this area have employed samples consisting of primarily moderate to high-income Caucasian families (e.g., Cohen & Mannarino, 1996; Friedrich, Luecke, Beilke, & Place, 1992; Lanktree & Briere, 1995).

Friedrich, Luecke, Beilke, and Place (1992) evaluated a treatment program developed for sexually abused boys. The treatment approach included a combination of group, individual, parent training, and family therapy. The boys in this study did not report a significant decrease in depression or an increase in self esteem. However, at follow up, clinical and statistically significant improvements were noted in a number of areas including overall behavior problems and sexual behavior problems. Therapy outcome was also related to a number of family and abuse factors, including maternal depression, and social support, family conflict, and severity of abuse. Although this study documented needed information about the treatment of sexually abused children, Friedrich et al. did not give a clear description of their design which obscures interpretation of the treatment results. For example, they write that "of the 42 boys who presented for treatment, 33 completed the program and pre- and post- data to a more or less complete degree, were obtained" (p. 399). In addition, they stated that the boys ranged in age from 4 to 16, but did not document how developmental age impacted therapy outcome nor did they check to see if the younger children comprehended the measures. Moreover, these results can only be generalized to male children.

The effectiveness of a more eclectic treatment program was also demonstrated by Lanktree and Briere (1996). The program consisted of abused-focused individual treatment, supplemented with group, family, and collateral parental treatment. Outcome of the multiple intervention approach was examined in a sample of 105 sexually abused children at 3 month intervals. Results indicated that the children showed continued declines in depression, anxiety, and post-traumatic stress at 3, 6, 9 months and 1 year. The authors examined the

rate of change in children's symptoms, and compared this with the time elapsed from the end of the abuse using multiple regression procedures. Results indicated that improvements in child subjective distress was due to treatment, rather than merely the result of the passage of time. In other words, the analyses indicated that time from the end of the abuse to either the beginning or end of treatment was significantly less predictive of decreases in child distress than the number of months spent in treatment. Additionally, these researchers used multiple measures which more specifically assessed the known ramifications of sexual abuse, and thus lending insight into the effectiveness of their treatment approach.

Other treatment outcome studies have focused on group counseling programs designed to ameliorate the behavioral and psychological manifestations of sexual abuse (e.g., Deblinger, McLeer, and Henry, 1990, De Luca et al. , 1993, Nelki & Waters, 1989). De Luca et al. (1993) assessed the effectiveness of a group counseling for girls who experienced intrafamilial sexual abuse. They found that children's self-report measures demonstrated a significant increase in self-esteem, and a significant decrease in anxiety. In addition, internalizing and externalizing behaviors as assessed by parents' responses on the behavior problem questionnaire, significantly decreased from pre- to post-treatment. However, there were no significant changes in loneliness. Again, although this study revealed valuable information regarding treatment, the results are suspect because of methodological problems. The study employed a very small sample size of 7 girls, did not include an operational definition of sexual abuse, and failed to give adequate descriptions of the subjects and the abuse incidents.

The efficacy of a group treatment program for 30 sexually abused girls between the

ages of 9 and 12 was documented in a study conducted by McGain and McKinsey (1995). These authors employed a matched control treatment design which was more methodologically sound than earlier studies on efficacy of the group treatment (e.g., Nelki and Watters, 1989; De Luca et. al., 1993). A waiting list control group was available due to the fact that not all of the children could be received into the treatment group immediately. The two groups were matched on severity of abuse and pre-existing symptoms. Significant treatment effects were found as the treated girls showed improvement in perceived problematic anxiety and misbehavior (e.g., school difficulties, socialized aggression, psychotic behavior) as compared to the waiting list control group. This study provides strong support for the use of group treatment for sexually abused girls.

### Current Study

This current study not only addresses the need for more treatment outcome studies but also attempts to avoid some of the problems uncovered in other investigations. This present study will utilize a variety of standardized outcome measures and a sample consisting of females as well as males. In addition, this study includes an operational definition of sexual abuse, a clear description of the subjects, design, and data analysis, and clinically meaningful descriptions of statistical analyses.

Overall findings indicate that there are a multitude of variables that may affect the psychological adjustment of sexually abused children including pre-abuse factors and the trauma of the abusive experience itself (Mannarino, 1992). Hence, a variety of outcome measures will be used to tap the various psychological and behavioral ramifications of sexual abuse. Child self-report measures will be supplemented with reports from their primary care

givers and their therapists. In addition, a detailed background information form for parents will be used in order to document relevant information about the child and the sexual abuse incident. Research also suggests that a multi-modal approach to the clinical treatment of sexually abused children may be appropriate. Children who have been sexually abused most likely can benefit from individual play therapy used in conjunction with cognitive-behavioral techniques, as well as parent guidance interventions addressing problematic behaviors, disrupted or disturbed family relationships, and family functioning, where appropriate. Thus, the therapists in this present study provided a variety of interventions based upon the individual needs of the child and family over time. This evaluation also included an assessment of sexual abuse prevention skill building and education techniques employed to supplement the therapeutic interventions. Treatment outcome research to date has not yet included an assessment of the development of sexual abuse prevention knowledge. Thus, this evaluation is designed to lend insight into the feasibility of successfully supplementing psychotherapy interventions, which tend to focus on decreasing pathology and psychological symptoms, with prevention skill building interventions, which, in contrast, tend to focus on increasing positive behaviors.

Program goals. This program evaluation was conducted in order to assess the effectiveness of a hospital-based treatment program designed to address the needs of children who have been victims of sexual abuse. The hospital's intervention has been designed with the following goals in mind:

1. Decrease the negative psychological effects of sexual abuse and decrease children's subjective distress including, anxiety, depression, fear and post-traumatic stress.

2. Decrease the negative behavioral effects of sexual abuse including, aggression, sexual acting out behavior, and sexualized behavior.

3. Enhance the children's sense of empowerment, adjustment, feelings of control, and perceived self-efficacy.

4. Educate the children about sexual abuse and increase prevention skills in order to prevent future victimization and perpetration. Educate appropriate family members about ramifications of sexual abuse and about the possibility of preventing future incidents.

5. Decrease family distress concerning the sexual abuse incident and increase appropriate family boundaries and family adjustment in the aftermath of the sexual abuse.

As can be discerned, these general goals address many of the psychological and behavioral ramifications of child sexual abuse discussed earlier. In addition, this program was developed to attempt to educate the families and children about sexual abuse in order to further preventive efforts. As mentioned above, a review of the literature uncovered little research which measured the outcomes of child sexual abuse therapy. The goals of the hospital's program and characteristics of children who have been sexually abused were used to guide the choice of measures described in the instrument package utilized in the present study.

Specific Hypotheses. The following hypotheses were derived with the above program goals in mind. With regard to variables pertaining to the children's subjective distress the following hypotheses were tested:

Hypothesis 1a: The participants will report a significant decrease in post-traumatic stress (PTS) symptoms between pre-testing and post-testing.

Hypothesis 1b: The participants will report a significant decrease in depression scores as assessed by the Child Depression Inventory (CDI) between pre-testing and post-testing.

Hypothesis 1c: Therapists will report a significant decrease in trauma symptoms as indicated by lower scores on the Traumagenic scale between pre-testing and post-testing.

With regard to the treatment program's impact on the negative behavioral ramifications of abuse. The following hypothesis was tested:

Hypothesis 2: Participants will report a significant decrease in behavioral symptoms as indicated by lower scores on the Child Behavioral Checklist (CBCL) between pre-testing and post-testing.

With regard to the program's impact on child empowerment, the following hypothesis was tested:

Hypothesis 3: Participants will show an increase in empowerment and feelings of self-efficacy and mastery as indicated by significantly higher scores on the perceived self-efficacy scale between pre-testing and post-testing.

With regard to the program's effect on the development of prevention skills and knowledge of sexual abuse incidents among child sexual abuse victims, The following hypothesis was tested:

Hypothesis 4: Participants will show an increase in knowledge about sexual abuse and prevention as indicted by significantly higher scores on the What I Know About Touching (WIKT) scale between pre-testing and post-testing.

In an effort to assess the programs impact on family functioning the following



hypothesis was tested:

Hypothesis 5: Participants will report an increase in family functioning as indicated by significantly higher scores on the Family Adaptability and Cohesion Scale (FACES) between pre-testing and post-testing.

## CHAPTER II

### METHOD

#### Sample Selection

Convenience or naturalistic sampling was used to select participants for this study. Participants were recruited from a community treatment center at a large metropolitan hospital in Chicago, Illinois. Male and female children between the ages of 6 and 16 who had come to the center to receive therapy specifically oriented toward children who have been victims of sexual abuse were recruited to participate in the study. Participants were referred to the treatment program from Child Protective Services, other hospital departments, social workers, case workers, pediatricians, psychologists, school personnel, community mental health agencies, and county and municipal police departments. Therapists asked families to participate in the study on a voluntary basis. All of the participants' histories of sexual abuse were established and investigated by Child Protective Services of Illinois prior to therapy. Only those children who met the specified criteria for being victims of sexual abuse were asked to participate. Sexual abuse was defined as sexual contact of an exploitive nature between the perpetrator and the victim. Sexual contact included direct genital, anal, and/or breast contact. Exploitation was defined as the involvement of developmentally immature children and adolescents in sexual activities that they do not truly understand. It also necessitated a difference in power between the perpetrator and victim with regard to be

size, age, and/or the nature of the emotional relationship. If the alleged sexual abuser was a minor, then he/she had to be at least five years older than victim. Alleged perpetrators, including those who were family members were not in the project and were not present for the assessments. The criteria for sexual abuse were derived from previous research (Schechter & Roberge, 1979; Mannarino, Cohen, & Gregor, 1989). Child participants who were mentally delayed and/or who were diagnosed as having a pervasive developmental disorder were excluded from the study.

### Sample Characteristics

A total of 8 families completed pre- and post-test data and were included in the data analysis for this program evaluation. Five additional families completed pre-test data but discontinued therapy prior to the completion of 8 sessions and thus were not included in the data analysis. One child's data were omitted because the child was deemed too young (4 years old) to comprehend the questionnaires. The mean age of treatment completers was 9.63 (range 6 - 16). Five of the children were female while three were male. The majority of the children were African-American (75%) while only one child was Caucasian and one of Latino ethnic origin. All of the families were deemed to have a low-income status (less than \$25,000 annual income). Half of the treatment completers resided with their single natural mother (4 participants), 3 of the children resided in relative foster care, while 1 child lived with both biological parents. Referral sources consisted of the following: Department of Children and Family Services (DCFS) (62%), physician or hospital department (25%), and social worker (13%). The mean period of time to complete 8 sessions of therapy was 3.8 months (range 2-10 months). The mean time since the sexual abuse incident was 2.2 years

(range 2 month -8 years). For the majority of the sample (6 of the 8 treatment completers), 5 months or more had elapsed between the abuse and the initiation of therapy. Attitude toward therapy was assessed by one item which read “How do you feel about your child receiving therapy here at the center?” (1=Very Good to 7=Not Very Good). The majority of the families had a positive attitude toward starting therapy at the center as 6 of the families reported that they felt “very good” about starting therapy.

With regard to sexual abuse, 3 children were abused once, 3 children were abused 2 to 5 times, and in 2 of the cases, the number of abuse episodes was not known. Four of the children were sexually abused over an extended period of time 3 months to 2 years. The types of abuse experienced were as follows: 5 children experienced anal and/or vaginal penetration, 2 experienced genital fondling and/or genital contact only and 1 was unknown. There was great variability in terms of perpetrator relationship to child victim. Identity of the perpetrator was as follows: 2 were biological fathers, 2 were neighbors, 1 was a cousin, 1 was Grandmother’s paramour, 1 was an uncle, and 1 was an older classmate. None of the children in this study were currently residing with their perpetrators. The majority of the families sought some type of legal action against the perpetrator (75%).

### Procedure

At the initial meeting, the children and their primary care givers were asked to read and sign consent forms (see Appendix A). In addition, to be sure that families comprehended the informed consent procedure, the research was described verbally and questions were encouraged. They were told that the research was being conducted to assess the effectiveness of the therapy and that the project was being done so that the hospital could be

sure that its program is meeting the needs of children who have been victims of sexual abuse. It was emphasized that their responses were strictly confidential. The subjects were also assured that their overt behavior during the hospital visits would not be evaluated so that this will reduce any evaluation apprehension that they may have had. Moreover, the children and their primary care-givers were told that in no way would they be denied services at the hospital if they decline from participation or decide to drop out of the study. This verbal information was standardized so that all participants received the same information.

At the initial meeting with the interviewer, the primary care-givers were asked to complete a background information form. This form consisted of questions that were relevant to the program's outcome such as the child's age, annual family income, severity and type of abuse, the child's relationship to the perpetrator, whether or not legal action has been taken against the perpetrator, etc. (see Appendix B).

The evaluation employed a pretest-posttest quasi-experimental design with no control group. Participants (the children, their nonoffending primary care-givers and their therapists) were asked to complete the measures immediately before the first therapy session and at the completion of 8 one-hour therapy sessions. In order to be sure that the children comprehended and completed the questionnaires, they were interviewed by an experimenter who was familiar with the questionnaires and who had extensive experience with using assessment tools of this nature. The parents completed the questionnaires and were encouraged to ask any questions that they may have had. The experimenter made extensive efforts to ensure that the children as well as the primary care-givers were understanding the questions. A preliminary analysis of the population revealed that most of the children were

old enough to comprehend the questions and most of the care givers were literate and English speaking. Upon completion of the pre- and post-test questionnaires, participants were fully debriefed.

### Description of Program and Treatment

Treatment took place at an out-patient mental health clinic affiliated with a medium sized urban hospital. Although this study focused exclusively on the treatment for child and adolescent sexual abuse victims, the clinic offers a wide-range of services for children, adolescents and adults. The majority of clients seek treatment at the hospital-based community program due to the following problems: family problems (e.g., conflicts between family members, marital conflicts, separation, divorce and other family crisis), personal problems (e.g., anxiety, depression, difficulty in interpersonal relationships), problems with children and adolescents (e.g., behavioral and/or adjustment problems at home or in school), emotional problems (e.g., need for psychiatric hospitalization, and problems of readjustment to family and community after discharge from the hospital). The center works in close collaboration with the other hospital departments (e.g., emergency room, inpatient and outpatient medical services), The Illinois Department of Mental Health, DCFS, and other community agencies. The staff includes psychiatrists, psychologists, social workers, a community worker, and a psychiatric nurse. The center serves the community surrounding the hospital. The majority of the clients are low-income African-American families who are referred by DCFS, self/family, schools, community agencies, intra-hospital staff and departments and other hospitals. The setting in which this study took place can be described as a non-research community agency with limited funding serving low-income clients. This

is in marked contrast to those treatment outcome evaluations described elsewhere (e.g., Lanktree & Briere, Cohen & Mannarino (1994, 1996), Nelki & Watters, 1994) which were characterized as specialized intensive sexual abuse treatment centers with substantial funding serving predominantly affluent Caucasian families. The clinical treatment of the child sexual abuse victims and their non-offending care-takers in this study was provided by 4 experienced clinicians with an average of 12.4 years experience (range 4-20 years) in treating children and families. The psychotherapists in the study were master's- or doctoral-level clinicians who have received specialized training in the clinical treatment of child sexual abuse.

A number of different modes of interventions were used to address the psychological sequelae of the sexual abuse victims and their families. The interventions used included individual child therapy (including play and cognitive therapies), parent guidance (involving support, guidance, and behavioral interventions), and family therapy (including the parent and child or the child with other family members). The interventions were designed to be culturally sensitive (e.g., therapeutic materials included use of African-American dolls, utilized illustrations of African-American and Latino families and children, use of games that were culturally appropriate) to the needs of the primarily low-income African-American sample, an under-served and understudied population (Mennon, 1994). The treatment can be described as an eclectic approach tailored to the needs of each individual child. This eclectic approach was adopted because sexual abuse is often associated with an extremely wide range of symptom patterns and treatment often confronts a very diverse set of children (of all ages, with a variety of histories and presentations, with many different symptom

patterns, and some without symptoms at all) (Finkelhor & Berliner, 1995). Additionally, sexual abuse treatment can be distinguished from other types of child psychotherapy due to the fact that sexual abuse is an experience, not a disorder or a syndrome. It can lead to disorders and syndromes, but is not one in itself. Treating children of diverse backgrounds and ages can be a complex task in which one type of therapy may not be appropriate for all children. This section describes those interventions used by the therapists in this treatment program.

In treatment, the children were encouraged to express how they felt through creative play interventions. Issues addressed in play therapy included, specific trauma and abuse experiences, care-taker and/or familial relationships, feelings toward the perpetrator (e.g., anger, ambivalence, fear), adjustment and coping, feelings of powerlessness, and the child's subjective distress (e.g., post-traumatic stress, anxiety, depression, and fear). The individual play therapy involved the use of artistic drawings, story telling techniques, toys and dolls, and certain board games to encourage children to express how they felt about the abuse incidents. The therapists in the study used a combination of directive and nondirective play therapy techniques (as described by Gil, 1991 ). The non-directive or client centered play therapy was non-intrusive as the therapist allowed and encouraged the child to choose the toys to play with and was given the freedom to further develop or discontinue a particular theme (e.g., anger about the victimization, feelings of fault and blame). Additionally, in accord with Gil's descriptions of non-directive techniques, the therapists observed the child at play and verbally affirmed what was seen. They paid close attention to the child's play themes and did not interrupt the play with directives or responses to questions. When



employing directive techniques, the therapists structured and/or developed play situations. Moreover, they attempted to elicit and draw out the child's cognitive processes and overt behaviors by encouraging or leading the child in play theme directions that were deemed beneficial. They also asked the child to draw specific scenes or tell exact stories. The directive play techniques also involved interrupting the sequence of play by asking the child to take a specific role and/or describe the perceptions or feelings of one or more of the play characters.

Cognitive-behavioral techniques were used to address problematic thought patterns about the abuse (e.g., self-blame, magical thinking, and intrusive fears) and inappropriate behavior (e.g., sexualized behaviors, excessive masturbation, or touching other children). Children's and/or parents' attributions and feelings concerning the sexual abuse incident were elicited and alternative ideas and behavior were promoted when appropriate. Issues addressed by the cognitive-behavioral techniques included the following (as discussed in Finkelhor and Browne, 1986): Negative connotations such as badness, shame and guilt that the child may have incorporated into his/her self-image following the abuse incident; sexual feelings and attitudes; feelings of betrayal due to the fact that someone important to them treated them with "callous disregard"; and feelings of powerlessness and lack of perceived self-mastery over events and experiences.

Therapists employed family therapy to address the impact on family functioning and dynamics. Various subgroups of family members, including parent-child, foster-parents and child, child and siblings, or the entire family attended sessions where the therapist attempted to enhance the authority of the parent role, promote appropriate communication, or improve

other aspects of family functioning. Additionally, the therapists worked to help caretakers understand the child's pain and grief over having been victimized, and process their own feelings about perceived failures to protect their child. Parent guidance typically involved educating parents on the effects of sexual abuse on their child and helping the parents cope with their own feelings about the trauma.

Interventions were also employed to promote education about sexual abuse in an effort to prevent further victimization of the child. The following were discussed: the concepts of good and bad touches related to public and private parts, secrets, body ownership, fault and responsibility, saying "no," telling a trusted adult, and leaving when touched in a way that brings discomfort. These concepts were introduced through the use of workbooks entitled, "Touch Talk: What to do if Someone Touches You and You Don't Like It" and "It's Your Body, You're the Boss!" (Berg, 1985), play therapy techniques, and cognitive-behavioral techniques. These issues were introduced in therapy in the hopes that the sexually abused children would learn skills to employ in difficult, frightening or other potentially abusive situations, and to establish feelings of power and safety. .

In order to control for possible extraneous variance due to predominant type of intervention received as well as potential variance from therapists' predominate mode of intervention, the specific types of interventions were coded for each session. The therapists were also asked to provide information on the program parameters (number of sessions attended, duration of session, attendance, and referrals). This information was examined and it was subsequently determined that there was sufficient similarity between the different therapists to justify aggregating the data (see Appendix C to view a copy of the therapy

session checklist).

### Outcome Measures

A variety of outcome measures were employed to tap information from the children, their primary care givers, and their therapists. Due to the difficulty involved in measuring the psychological ramifications of sexual abuse and adaptive functioning in child sexual abuse victims, multiple outcome measure were selected to assess the children's self-reported emotional difficulties and the children's overt behaviors as reported by a variety of independent sources. For each measure, evidence for reliability and validity was considered as a selection criteria. Although the dearth of therapy outcome research made the selection of appropriate outcome measures somewhat difficult, the measures chosen have been used extensively in the child psychopathology literature (e.g., The Children's Depression Inventory, Child Post-Traumatic Stress Reaction Index, Child Behavior Checklist) and have been used extensively to assess symptomatology in the area of child sexual abuse (Cohen & Mannarino, 1988, 1989, Mannarino et al., 1989, 1991; De Luca et al, 1993). The instruments utilized in this study were also selected, in part, because of their careful standardization and the availability of normative data. The participants were also asked open-ended questions to assess their thoughts and feelings regarding beginning therapy and if the therapy met their needs.

### Child Self-Report Measures

Child Depression Inventory. The CDI (Kovacs, 1981) is a 27-item self-rated symptom oriented scale suitable for children aged 6-17. The CDI is the most commonly cited and thoroughly researched self-report measure of childhood depression (Finch, Conway,

Edward, 1985). Each of the 27 items on the CDI consists of three choices and the respondent is instructed to select the choice for each item that best describes his/her behavior over the immediately preceding 2 weeks. Item choices are keyed from 0 to 2 in the direction of increasing symptom severity. Sample items read, "I am sad once in a while, I am sad many times, or I am sad all the time" and "I have fun in many things, I have fun in some things, or nothing is fun at all."

Child Post-Traumatic Stress Reaction Index. The child PTS Reaction scale (Frederick, Pynoos, & Nader, 1992) is a 20-item scale self-report scale designed to assess posttraumatic stress reactions of school-age children and adolescents after experiencing a broad range of traumatic events. Items measure a variety of post-traumatic stress disorder symptoms including the following: experiencing reminders of the event, intrusive images and thoughts, recurrent distressing dreams, feeling upset or tense when thinking about the event, fear of recurrence, diminished interest in activities, interpersonal distancing, numbing of feelings, and avoidance of activities. Empirical comparisons of the reaction index scores with independent clinical assessments for severity levels of PTS in children resulted in these guidelines: a score of 12 to 24 indicates a mild level of PTS, 25 to 39 a moderate level, 40 to 59, severe, and greater than 60, very severe. The scale includes a five-point Likert frequency rating scale ranging from "none" to "most of the time." Sample items read, "Is what happened to you something that would upset, or bother most children your age a lot," "Do you have good or bad dreams about what happened or other bad dreams," and "Do thoughts about the event come back to you even when you don't want them to." Inter-item reliabilities have been reported at 94% and Cohen's kappa alpha has been reported as .878

(Pynoos, 1987).

Perceived Self-Efficacy Scale for Children. This is a 20-item self-rated scale suitable for children between the ages of 5 and 12. This scale was developed to measure coping as well as persistence in the face of adversity. A sense of efficacy has been found to correlate highly with other measures of children's psychological well-being and effective functioning following stressful or traumatic life events (Cowen, Work, Hightower, Wyman, Parker, & Lotyczewski, 1991). Cowen et al. report that the scale has acceptable psychometric properties, a meaningful factor structure, and adequate convergent and divergent validity. In addition, they report that it has adequate internal consistency and test-retest reliability. The scale has been shown to have a test-retest reliability of .65 and an alpha of .81. Subscale alphas ranged from .41 to .71. Respondents are asked to respond to a 5 point scale ranging from "not at all sure" to "very sure." Sample items read, "How sure are you that things will work out well for you when you meet a person for the first time," "if you have to travel to new place by yourself," and "when you feel very unhappy." Two items were added to this scale in order to assess perceived efficacy in regard to the ability to protect oneself in the event of a sexual abuse attempt. The items read "How sure are you that you can tell a trusted adult if someone touches a private area of your body," and "How sure are you that you can say 'no' if someone touches a private area of your body."

What I Know About Touching Scale. This questionnaire was designed to measure children's knowledge about sexual abuse and its prevention. Items cover the following concepts: definitions of sexual abuse, characteristics of abusers, who can be sexually abused, it's okay to say no, it's okay to tell about the sexual abuse, and the sexual abuse is not the

child's fault. This self-report questionnaire uses yes/no/I don't know format. Correct answers receive 1 point whereas incorrect answers or "I don't Know" responses receive 0 points. Total scores can potentially range from 0 to 25 points (Hazzard, Kleemer, & Webb, 1990). Sample items read: "Do you think children should always obey grown-ups," "Are the private parts of your body the parts that no one else has the right to touch without your permission," "If someone touched your private parts without your permission, would it be your fault because you weren't careful enough," "Is it a good idea to yell if someone touches you in a way that scares you," and "Should you keep secrets when grown-ups tell you to."

#### Measures Administered to Parents

Child Behavior Checklist-Parent Form. The CBCL (Achenbach, 1978) was developed as a descriptive rating instrument to measure both adaptive competencies and behavior problems. The parent version includes 113 items that identify a variety of behavioral and adjustment problems. There are also questions related to the children's activities, interests, social relationships, and academic functioning at school (referred to as social competence scales). In addition, this scale measures internalizing syndromes (e.g., depressed, immature) and externalizing syndromes (e.g., hyperactive, inattentive) relevant to children. Achenbach (1991) reported strong construct validity and criterion validity and test-retest reliabilities of .87 for all the competence scales and .89 for all problem scales.

Family Adaptability Rating and Cohesion Scale II (FACES II). This instrument was developed to measure family functioning and was utilized to get information regarding the child's context and the family's level of functioning following the trauma of sexual abuse. FACES II (Olsen, 1982) is a 30-item scale developed to measure the cohesiveness of family

relationships and appropriate family boundaries. According to Olson et al.'s scoring interpretation, family cohesion guidelines are as follows: score 71-80 indicates a very connected family system, score 60-70 is connected, score 59-51 is separated, and score 15-50 is disengaged. In term of adaptability the guidelines are as follows: score 55-70 is very flexible, score 46-54 is flexible, score 40-45 is structured, and score 15-39 is rigid. Respondents are asked to read statements and decide for each item how frequently, on a scale that ranges from 1 (almost never) to 5 (almost always), the described behavior occurs in his/her family. Some of the items are reversed scored. Sample items read: "Family members are supportive of each other during difficult times," "When problems arise, we compromise," "Our family does things together", and "Family members consult other family members on personal decisions." Cronbach alpha figures for the scales are .87 (Cohesion items) and .78 (Adaptability items).

#### Measures Administered to Therapists

Traumagenic Impact of Maltreatment Rating Summary. This scale was developed to measure the major psychological sequelae of child maltreatment. The items are categorized into nine traumagenic areas, each with several common behavioral manifestations: traumatic sexualization/eroticization, betrayal and loss, stigmatization, powerlessness, self-blaming, destructive acting out, loss of body integrity, development of dissociative disorder, and development of attachment disorder (James, 1989). The therapist responds to each item on a ten point scale ranging from 1 (absent) to 10 (severe, e.g., "violent, destructive, or sadistic behavior").

## CHAPTER III

### RESULTS

#### Child's Subjective Distress

One-tailed paired  $t$  tests were employed on the dependent measures to test the hypotheses and to determine the program's effectiveness. Table 1 contains the means and standard deviations for all measures before and after treatment. In addition to assessing change on pre-test and post-test scores by employing traditional statistical procedures, the mean scores of the treated children were also compared with the means and standard deviations of the normative samples used to construct the dependent measures if available. Post-treatment mean scores that were within the limits of the "normal population" were be considered to have changed in a clinically meaningful way.

With regard to variables pertaining to children's subjective distress, results indicated significant changes on the Post-Traumatic Stress Reaction Index, the Child Depression Index and the Traumagenic scale. The children reported a significant decrease in PTS scores between pre-testing and post-testing as indicated by pairwise one-tailed  $t$ -test results,  $t(7) = 2.17$ ,  $p < .03$ , Cohen's effect size  $d = .72$ . According to Lipsey (1990), this result suggests that the treatment is having a "large" effect on post-traumatic stress disorder symptoms (p. 56). Additionally, the mean value for the PTSD scale at pre-test ( $M = 38.8$ ) indicated a "severe" degree of disorder while the mean raw score value at post-test ( $M = 46.7$ ) indicated



a “moderate” degree of disorder as compared to normative indexes of severity. Child respondents also reported a significant decrease in depression scores between pre-testing and post-testing (one-tailed),  $t(7) = 2.08$ ,  $p < .04$ , Cohen’s  $d = .76$ . These results also suggest a large program impact on depression scores. Mean CDI scores at post-test ( $M = 9.75$ ,  $SD = 9.77$ ) were in the normal range. Therapists reported a significant decrease in trauma symptoms as indicated by scores on the Traumagenic scale between pre- and post-testing (one-tailed),  $t(6) = 4.94$ ,  $p < .001$ ). One therapist’s rating was omitted due to an outlying score.

#### Negative Behavioral Ramifications and Perceived Self-Efficacy

No significant changes were noted in behavioral symptoms as assessed by the Child Behavioral Checklist. However, complete data were only available for 3 participants. Those participants with missing data were omitted, and thus only a small amount of data was available to conduct the statistical analysis on,  $t(2) = 1.70$ ,  $p > .05$ . Results also showed that the program had a non-significant impact on perceptions of self-efficacy among child participants (one-tailed),  $t(7) = 1.05$ ,  $p > .05$ . Analysis of the two items assessing body mastery indicated non-significant changes between pre- and post-treatment. Although the results on these measures assessing the behavioral ramifications of sexual abuse and children’s perceived self-efficacy did not indicate a significant program impact, it is noteworthy that the results were in the hypothesized direction.

#### Prevention, Education, and Family Functioning

With regard to the program’s effect on the development of prevention skills and knowledge of sexual abuse, results showed a “medium” program impact, Cohen’s effect size

$d = .42$  (Lipsey, p. 56) Child participants had significantly higher scores on the What I Know About Touching Scale at post-treatment,  $t(7) = 3.13$ ,  $p < .01$ .

The pairwise  $t$ -tests revealed non-significant changes in family adaptability and cohesion scores between pre- and post-testing. After obtaining the total cohesion scores, results indicated that the sample presented with cohesion scores ( $M=51$ ) that were in the “separated” clinical range as indicted by the scale’s indexes of severity. According to the test authors, this mean score is only 1 point away from being characterized as being in the “disengaged” clinical range. In other words, these results suggest that the families in this sample have relatively low levels of cohesion and consist of members that feel separated or disconnected from other family members (Olson, et al). In terms of adaptability, results indicate that the sample presented with adaptability scores ( $M=40$ ) in the “structured” range. This finding implies that the families in this sample tend to be rigid and unable to change.

#### Comparison of Treatment Completers and Drop-Outs

In order to determine if there were differences between the sample that completed treatment and those who discontinued prior to the completion of 8 therapy sessions, the respective child participants were compared along demographic and abuse characteristics. Results showed that those who completed treatment ( $n = 8$ ) were not significantly different from those who did not complete post-test data ( $n = 5$ ) along a number of variables including gender, race/ethnicity, care-giver relationship, perpetrator relationship, legal action pursued, foster care status, care-giver marital status, months since abuse, and number of abuse incidents/duration of abuse, and therapy attitude. Differences were found between the two groups with regard to the duration of abuse (in months), such that the duration of abuse for

those who discontinued ( $M = 1.25$ ) was significantly shorter than those who completed treatment ( $M = 13.33$ ),  $t(5) = 2.48$ ,  $p < .05$ .

Table 1

Means and Standard Deviations for Treatment Outcome Measures

Measure	<u>Before Treatment</u>		<u>After Treatment</u>		N
	Mean	S. D.	Mean	S. D.	
Post-Traumatic Stress Reaction Index	46.75*	(11.29)	38.88*	(10.64)	8
Child Depression Inventory	16.50*	(10.10)	9.75*	(7.59)	8
Traumagenic Scale	47.00*	(18.35)	31.43*	(22.52)	7
Child Behavior Checklist	88.33	(54.28)	64.00	(29.46)	3
Perceived Self-Efficacy	58.62	(12.49)	62.13	(10.01)	8
Body Mastery	5.57	(3.46)	6.43	(2.88)	8
What I Know About Touching	13.50**	(4.07)	15.25**	(4.27)	8
Family Adaptability	40.57	(7.74)	43.86	(6.77)	8
Family Cohesion	51.00	(12.32)	51.71	(12.70)	8

Note. \*  $p < .05$ ,  
 \*\*  $p < .001$

## CHAPTER IV

### DISCUSSION

This program evaluation offers a number of findings regarding treatment outcome for child sexual abuse victims. Results suggest that short-term eclectic intervention approaches may be effective in reducing child subjective distress such as depression, post-traumatic stress and abuse trauma. Additionally, results indicated that prevention education and skill building techniques in conjunction with other psychotherapy interventions (individual, play therapy, cognitive-behavioral, and family therapy) may be effective in increasing knowledge about prevention skills and issues regarding sexual abuse among sexually abused males and females. However, results indicated that the treatment program is having a non-significant impact on children's perceived self-efficacy and family adaptability and cohesion. It is possible that these factors are more enduring and that this short-term treatment had no impact on these individual and family characteristics. It is also possible the sample size was not large enough to allow the statistical procedures employed to detect an effect.

It is noteworthy that those child participants who had a shorter duration of sexual abuse were more likely to discontinue therapy than those with a longer duration of abuse. It is possible that the families perceived the sexual abuse of a shorter duration as not severe enough to deem treatment necessary. These results were consistent with findings

from research conducted on the factors associated with entry into therapy for children evaluated for sexual abuse (Tingus, Heger, Foy, & Leskin, 1995). Those children who were most likely to enter therapy had experienced abuse of greater frequency than those sexually abused children who did not enter into a program of treatment.

This study also lends insight into the effectiveness of treatment for low-income African-American families. In terms of treatment outcome for sexual abuse victims, this group has been under-researched and poorly understood. Tingus et al. (1995) found that Caucasian children were more likely to receive therapeutic intervention following presentation of sexual abuse than other Latino and African-American children. Many complex cultural and economic variables may contribute to the fact that Latino and African-American children are at high risk for not receiving treatment. More research is needed in this area to fully understand the reasons why these two ethnic groups are underserved. Moreover, the present study also revealed a high attrition rate for those low-income African-American families who did enter therapy (65% dropped out of treatment before completing 8 sessions). Future treatment outcome studies on child sexual abuse should systematically examine factors associated with attrition in order to enhance knowledge concerning the ability to provide effective treatment. A systematic examination would necessitate follow-up with those families who discontinued therapy, not simply an examination of pre-treatment data.

This study has many potential strengths as well as weaknesses. The strengths include the fact that this study had strong ecological validity because it took place in an actual setting that treats child sexual abuse victims, and that multiple outcome measures

were used to tap information about the child's emotional symptoms as well as behavioral symptoms to improve construct validity of the effect. In addition, child self-report measures were utilized along with instruments that assess the child's overt behavior from a variety of sources including their primary care givers, and their therapists. It is very difficult to measure psychological well-being and effective functioning particularly in young children. Therefore, a variety of self-report and behavioral outcome measures were utilized. These multiple measures converged to indicate more valid and reliable results. This research also provides information regarding the treatment of child sexual abuse victims that may guide future research in this area. Most importantly, this research responds to the pleas for more empirical investigations in this area and may aid in the development of effective treatment programs for victims of child sexual abuse.

One of the most significant weaknesses with this quasi-experimental pretest-posttest research design is the lack of a control group. Without a control group it is difficult to rule out threats to internal validity such as maturation, statistical regression, and history. However, due to practical and ethical considerations, a control group was not feasible. The hospital did not have access to children who would serve as appropriate control subjects. Moreover, the hospital could not justifiably deny treatment to children who have been victims of sexual abuse, and naturally the hospital could not practically randomly assign children to sexual abuse conditions. The absence of a comparison group makes it impossible to determine if the findings are due to a maturation effect (Cook and Campbell, 1979). In other words it is difficult to determine if the children experienced symptom reduction due to the passage of time or due to the interventions. A variety of

researchers have employed statistical procedures to test the maturation hypothesis (e.g., Lanktree and Briere, 1995). To determine if changes in outcome measures could be accounted for in terms of maturation, treatment evaluation researchers have employed multiple regression analyses, using change scores on the outcome measures as dependent variables and total months in treatment, and time elapsed since abuse was disclosed to the end of treatment as independent variables. This technique has been found to be effective in showing that effects could be explained by the therapy interventions rather than in terms of maturation. However, due to the small sample size in this current study, this multiple regression procedure was deemed inappropriate as results were unlikely to be statistically meaningful. Although this statistical technique was not used, characteristics of the sample lend insight into the probability of effects being due to maturation. For the majority of the children, a great amount of time had passed elapsed between abuse and the initiation of therapy (6 months to 8 years). Despite the fact that a significant amount of time had passed since the abuse, all the children presented with depression and post-traumatic stress symptoms in the “severe” category as indicated by the normative indexes of severity available for these scales.

It is possible that the detected changes between pretest and posttest scores could be due to statistical regression rather than the impact of treatment. An examination of the pretest and posttest scores revealed that many of the outcome measures (e.g., CDI, PTS, and the Traumagenic Scale) were in the extreme categories at pretest. The statistical significance obtained could be due to regression toward the mean. One way to rule out statistical regression is to employ a design that includes several posttest sessions over a

long period of time and examine the stability of treatment impacts over time (Cook & Campbell, 1979). This study only included one posttest session meaning that statistical regression could be a threat to this evaluation's internal validity. However, according to Cook and Campbell choosing outcome measures with adequate reliability serves to decrease the probability of regression toward the mean. The outcome measures utilized in this study were chosen partly because of their high degree validity and reliability, and thus the probability of statistical is partially reduced. Moreover, the long period that elapsed before initiation of therapy makes statistical regression seem less feasible. It is seems implausible that the victims suddenly showed improvements.

In an effort to rule out effects that could have been due to extraneous factors that were not part of the evaluated program a content analysis was conducting using the qualitative data obtained from the Background Information Form documenting any special school-based programs concerning sexual abuse that may confound with treatment. Qualitative data indicated that the children had not obtained any additional forms of treatment (e.g., school based-counseling or child sexual abuse prevention program). These additional treatment sources, had they been present, would be expected to inflate the apparent effectiveness of the program.

The treatment approach was heterogenous and included individual as well as family therapy and varied from individual to individual, which made it difficult to identify precisely which aspects of the treatment were effective. However, this poses a dilemma because tailoring the treatment to meet the needs of the individual clients is an effective approach to therapy but is detrimental to the ability to make causal inferences.



Another potential problem is demand characteristics. The families and therapists knew that they were in the study and may have shown improvements simply because they were trying to please the experimenters and merely because they were in a being “evaluated.” However, it does not appear that the participants were merely responding favorably to the questionnaire items and/or to the interview questions due to the fact that not all outcome measures were significantly different at post-test.

This research was conducted in order to assess the effectiveness of a hospital-affiliated community treatment program for child sexual abuse victims and to determine if the services provided were meeting the needs of the children and their families. The data gathered in this study are being used to improve the program and may facilitate the development of more effective treatment programs in other settings. Moreover, this study responds to the need for more empirical investigation in the area of child sexual abuse treatment. The research is being continued in an effort to obtain a larger sample. By assessing both the amount of change and comparing post-treatment scores with normative indexes of severity a more meaningful evaluation of the program was conveyed (cf. Beutler & Hill, 1992). The author hopes that this investigation provides valuable information that will help children and their families cope with the distressing ramifications of sexual abuse.

APPENDIX A

ADMINISTRATIVE CONSENT FOR PARTICIPATION

**Administrative  
Consent for Participation  
in an Experimental Project**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

1. I, \_\_\_\_\_, state that I am \_\_\_\_\_ years of age and I wish to  
(Type or Print Name)

participate in a program of medical research being conducted by: Mary Jo Rogers,  
Ph.D.

(Physician/Investigator)

2. The purpose of the research is:

The purpose of this of this research is to determine whether the Community Guidance Center is meeting the needs of children who have been victims of abuse. This research will involve assessing the behavior of children receiving services at the Community Guidance Center.

3. The experimental procedures are:

The specific tasks I and my child will perform require: Filling out a series of confidential questionnaires immediately before the start of the therapy at the Community Guidance Center, after 8 therapy sessions and again after 8 more therapy sessions. Only my child's and my answers to the questionnaire will be used in the study . My answers to the questions will be strictly confidential and used for research purposes only.

4. The personal risks involved are (if none, so state): None

I understand that my confidential responses to the questionnaire items will not be reported to Child Protective Services or any other agency or department.

5. Potential benefits:

Although I may not benefit personally, the information obtained in this study may be used to help in the development of better treatment programs to help child abuse victims and their families cope with the distressing circumstances associated with abuse.

6. I understand that I will receive standard medical care, if required, even if I do not participate in this study. Alternative procedures and therapy that may benefit me personally are:

None. I understand that my participation in this research project is entirely voluntary and

in no way will my participation in this study affect my services obtained at Mercy Hospital. In addition, I realize that I may withdraw from this study at any time without judgment or penalty.

7. I understand and accept the following research related costs (this refers to costs which are beyond those required for my normal diagnostic and treatment purposes ). If no additional research costs are to be paid by the patient/participant state NONE. NONE

**8. Compensation Statement** (Check appropriate statement and denote N/A where not applicable.)

X a. I understand that in the event of physical injury resulting from this research there is no compensation and/or payment for medical treatment from Mercy Hospital and Medical Center. For such injury except as may be required of Mercy Hospital and Medical Center by law.

N/A b. I understand that in the event of physical injury resulting from this research, compensation and/or medical treatment may be available from...  
\_\_\_\_\_ (who is sponsoring this research). I understand that if I believe I am eligible for compensation for medical treatment, I may contact...

**9. Adult's Consent** (Check appropriate statement and denote N/A where not applicable).

  X   a. I acknowledge that I have been informed that this procedure is not involved in my treatment and is not intended to benefit my personal health.

\_\_\_\_\_ b. I acknowledge that I have been informed that this procedure is also designed to assist in maintaining or improving my personal health and will benefit me personally in the following way:

**10. Minor's Consent** (Check appropriate box and denote N/A where not applicable).

We, the parents or guardians of the above minor volunteer, agree to his/her participation in research project outlined above. We have been informed of the need for the research, the benefits derived from it, and the risks involved. We have also been informed that the research cannot be conducted with adults because of the nature of the study.

  X   a. Being aware of the necessity for the participation of minors in this research project and further being aware that the procedure will not personally benefit the minor here involved personally, we consent to the minor's participation.

- \_\_\_\_\_ b. Being aware of the necessity for the participation of minors in this research project and being informed that the procedures will also benefit the above-named minor personally, in the following way:

We consent to the minor's participation

\_\_\_\_\_  
Patient (Including Minor)      Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Parents or Guardians      Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Physician/Investigator      Date

\_\_\_\_\_  
Print Name

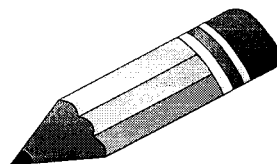
\_\_\_\_\_  
Witness of Explanation to Subject      Date

\_\_\_\_\_  
Print Name

APPENDIX B

BACKGROUND INFORMATION FORM

## Background Information Form



Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Child's Date of Birth: \_\_\_\_\_ 2. Gender: ☐ Male ☐ Female 3. School Grade: \_\_\_\_\_

4. If your child is in a special class room, what type is it? \_\_\_\_\_

5. Annual Family Income:

a. ☐ Under \$25,000 b. ☐ \$25,000-\$50,000 c. ☐ Over \$50,000

6. Child's ethnic background:

☐ African-American

☐ Asian-American

☐ Caucasian

☐ Latino

☐ Other: \_\_\_\_\_

7. Care-giver's relationship to child:

☐ Natural mother

☐ Aunt

☐ Natural father

☐ Uncle

☐ Grandmother

☐ Cousin

☐ Grandfather ☐ Other: \_\_\_\_\_

☐ Non-Relative Foster Parent

8. Marital Status:

☐ Married ☐ Divorced

☐ Single ☐ Separated

9. Child's Siblings (include ages and genders):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Is this child currently in foster care? Please describe: \_\_\_\_\_

11. Date of alleged or actual abuse: \_\_\_\_\_ Date reported: \_\_\_\_\_ Who reported: \_\_\_\_\_

12. To your knowledge, how long had abuse been going on?: \_\_\_\_\_

13. Please describe the abuse to your knowledge: \_\_\_\_\_

14. How many other abuse incidents involving this child are you aware of? Please describe: \_\_\_\_\_

15. Alleged or actual abuser's relationship: \_\_\_\_\_ Alleged abuser's age: \_\_\_\_\_

16. Is the child currently living with alleged or actual abuser?: \_\_\_\_\_

17. Has any legal action been undertaken? Please describe: \_\_\_\_\_

18. Has he/she ever received therapy before? Please describe: \_\_\_\_\_

19. Who referred you to the Community Guidance Center (e.g., Physician, Friend, DCFS, School)?

20. To your knowledge, is your child currently involved or been involved in any program(s) dealing with the issue of abuse (e.g., at school)? Please describe:

---

21. How do you feel about your child receiving therapy here at the Community Guidance Center? Please circle one number:

Very Good						Not Very
Good	1	2	3	4	5	6 7



APPENDIX C  
THERAPY SESSION CHECKLIST

# Therapy Session Checklist ✓

Please Complete After Each Therapy Session!!

Date: \_\_\_\_\_

Therapist Name: \_\_\_\_\_ Child's Name: \_\_\_\_\_

Compliance: (circle)

Attended   Over 20 minutes late   Rescheduled   Canceled   Did not Attend/Did not Call

Please document Outreach Attempts that you made to increase compliance:

Date(s): \_\_\_\_\_ Out Reach Attempt(s): \_\_\_\_\_

If the family has been inconsistent in attendance or noncompliant please indicate the reason(s) why:

General Reaction to Interventions:(circle)

Very Receptive

1

2

Somewhat Receptive

3

4

Mostly Unreceptive

5

Characterization of Therapy Session: (circle all that apply)

## 1. Play Therapy Techniques:

- A. Individual child session focusing on specific trauma and abuse experiences
- B. Individual child session focusing on caretaker and/or familial relationships
- C. Individual child session focusing on feelings toward the perpetrator
- D. Individual child session focusing on adjustment and coping
- E. Individual child session focusing on feelings of powerlessness
- F. Individual child session focusing on child's subjective distress (e.g., post-traumatic stress, anxiety, depression, fear).

## 2. Cognitive Behavioral Techniques:

- A. Individual child session focusing on specific trauma and abuse experiences
- B. Individual child session focusing on caretaker and/or familial relationships
- C. Individual child session focusing on feelings toward the perpetrator
- D. Individual child session focusing on adjustment and coping
- E. Individual child session focusing on feelings of powerlessness
- F. Individual child session focusing on child's subjective distress (e.g., post-traumatic stress, anxiety, depression, fear).
- G. Individual child session focusing on teaching appropriate behavior
- H. Parent-child session focusing on teaching appropriate behavior
- I. Consulting with parents regarding: \_\_\_\_\_

### 3. Family Therapy Approaches:

- A. Individual parent session providing support and processing of personal difficulties that affect child's adjustment
- B. Individual parent session focusing on coping with the child's trauma
- C. Individual parent session focusing on child management and/or discipline techniques
- D. Care giver-child session focusing on care-giver child relationship
- E. Care giver-child session focusing on familial relationships
- F. Care giver-child session focusing on appropriate behavior
- G. Family session focusing on familial relationships
- H. Family session focusing on appropriate behavior

### 4. Prevention Skill Building Techniques:

- A. Session focusing on recognition of appropriate and inappropriate touching
- B. Session focusing on child's ability to say "no" and tell a trusted adult
- C. Session building feelings of control over body

Please list the titles of all materials used to supplement your interventions (e.g. **BOOKS, GAMES, MOVIES, FILMS**) also include the purpose of the material (e.g. decrease distress, improve family relationships, prevention skill building, etc.,)

Title: \_\_\_\_\_ Type: \_\_\_\_\_ Purpose: \_\_\_\_\_

Title: \_\_\_\_\_ Type: \_\_\_\_\_ Purpose: \_\_\_\_\_

Title: \_\_\_\_\_ Type: \_\_\_\_\_ Purpose: \_\_\_\_\_

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## VITA

The author, Michele Hansen, is the daughter of JoAnn Hansen and James Hansen. She was born on May 27, 19~~98~~<sup>70</sup> in Greenville, Michigan.

The author received her Bachelor of Arts degree in psychology at Michigan State University in May, 1993. During her training at Loyola she completed a research internship at Mercy Hospital and Medical Center in Chicago as well as an internship at Loyola University's Department of Student Diversity in the Division of Student Affairs. Her research interests include program evaluation methodology, treatment of abused and neglected children, and organizational factors that impact employee burnout and motivation.

**From:** <MHANSE70@aol.com>  
**To:** <SISRAIL@wpo.it.luc.edu>  
**Date:** Thursday, July 27, 2000 4:09 PM  
**Subject:** Re: URGENT!Need your correct BIRTH YEAR for Thesis

My birthdate is 5/27/70. I apologize for the error.

--Michele Hansen

Approval Sheet

The thesis submitted by Michele Hansen has been read and approved by the following committee:

Dr. Fred Bryant, Director  
Professor, Psychology  
Loyola University Chicago


Dr. Emil Posavac  
Professor, Psychology  
Loyola University Chicago

Dr. Mary Jo Rogers  
Clinical Psychologist  
Mercy Hospital and Medical Center

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with references to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

3/31/98  
Date

  
Director's Signature